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Remarks of
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before
The Goldman, Sachs Health Care Conference
April 2, 1986

I'm glad to be able to be with you this afternoon. This conference is taking place at the beginning of the real budget season, at a time when the groundwork is laid for the rest of the Session's deliberations.

During these budget discussions, it is clear that health programs are under attack as never before. All of us who care about them--as providers, employers, and patients--must work together for their preservation. Without such combined effort from participants in the health care market, few Federal programs will be left intact and effective.

Gramm-Rudman

No where is this more evident than in the enactment of the Gramm-Rudman legislation. As you may know, starting last month, the Medicare program began paying 99 cents on the dollar to physicians, hospitals, and other providers. In addition, most of the health programs within the jurisdiction of my subcommittee were cut by 4.3 percent.

These cuts pose problems in all areas--ranging from research to clinical care. They cause particular difficulties in regulatory agencies such as the FDA and the CDC in which almost all funding goes for staff. Already stretched thin, the staffs are being further reduced in size and we can only expect that work will be slowed, no matter what the de-regulatory rhetoric may be.

As the President refuses to consider reductions in defense or increases in taxes, further Gramm-Rudman cuts--at least twice as deep--can be seen on the horizon for September, and the effect for the patient and the health care industry will be devastating.

I was a conferee on the Gramm-Rudman bill. I did what I could during negotiations to minimize the damage to Medicare, Medicaid and other health programs, but I did not sign the conference report and I voted against passage of the bill.

You may have heard that one of the authors of the bill, Senator Rudman, called it "a bad idea whose time has come. I agree that it is a bad idea, but it is a bad idea whose time should never have come.

President's Budget for 1987

Unfortunately, the President's budget proposals for 1987 are no better. The President proposes to cut federal health spending by nearly $73 billion over the next five years. Medicare would be slashed by almost $53 billion, Medicaid by nearly $10 billion, and biomedical research and public health programs by over $10 billion.

Even the most simple fundamentals are under attack:

The President's budget proposes cutting funds for the childhood immunizations against polio and measles, diseases we know we can control.

The budget includes a real decrease of over 20 percent in AIDS activities at NIH and CDC.

The Administration argues that biomedical research be cut by 1,000 new grants and 1,000 new fellowships.

And the President, for the sixth year in a row, is proposing to limit the Federal share of Medicaid and leave States and hospitals with whatever extra costs there may be.

Such proposals are unreasonable. They do not make a coherent approach to the role of government in health care.

Government's role

Government budget policies should be made from the individual substance of the programs and the problems they are meant to address.

o First we should look at individual problems and potential remedies.

o Then we should look at the markets and incentives for such remedies.

o We should identify those places where the market doesn't work, what economists call "market failures," and what others might call "social inequities."

o And we should try to prevent those market failures that hurt people and damage the nation's economy.

Annual budgets are important, but we should not be misled by short-term savings into long-term mistakes. Today's savings in AIDS research are tomorrow's costs in health care. This year's scrimping on FDA is next year's delay in approving new drugs.

And whatever savings are involved, we must also look to the ethics of care and to the rights of Americans. We have made a promise that poor families and elderly people will receive basic care. We have also promised that hospitals will be paid for providing such care.

Looking at all Federal programs, virtually everyone agrees that health programs are different from other budget items, that they cannot be treated like other services and commodities. The purpose of government is also to assure the protection of basic rights and services for all Americans. Health care is one of the areas where the Federal government clearly has a responsibility. This responsibility includes promoting and safeguarding the public health, assuring the conduct of basic research, and assuring access to care for all Americans -- especially - the poor, the disabled, and the elderly.

Nothing in Gramm-Rudman and very little in the President's budget lives up to this role of government.

Specific financial interests

But by saying that, I do not mean to imply that the Congress will not be actively working. While this is the Congress that has tied itself down with the ropes of Gramm-Rudman, there are some constructive attempts to deal with budgets and with legislative change. Let me give you a few examples of areas that you might be particularly interested in.

Prospective payment

The first question that most people in the health industry ask is whether prospective payment is here to stay.

Yes.

The system has a number of shortcomings. It doesn't truly recognize the special needs of hospitals that serve a large number of poor and uninsured people, especially public hospitals. And it doesn't have an efficient method for dealing with a new and expensive diagnosis, like AIDS.

But prospective payment for hospitals will be a fact of life in the Medicare program, and, I believe, in other programs as well. Large employers, and state systems will all approach DRG's as a way to compete and to enhance efficiency.

As the Congress continues to watch this approach, however, it will become important for us to investigate what prospective payment means for those without any source of payment. There are an estimated 35 million Americans without any form of health insurance, and we cannot allow those people to be shut out of hospitals. No one competes for them. In fact some institutions refuse to serve them. And, if no one factors their costs into the prospective payment for others, no one will care for them.

Capital

There is another particular problem in the prospective payment system under Medicare, a financial problem that is getting increasing attention in the Congress and in the Administration--the problem of how to reimburse for capital expenditures.

As many of you know, the Reagan Administration has proposed to make major changes in capital reimbursement by regulation alone. The Administration proposal folds all capital payments into the DRG payment.

I would point out that the Administration wants to proceed with this dramatic change even though the Department of Health and Human Services has never submitted the report on capital mandated in the 1983 Medicare amendments and due in October 1984.

I find this completely unacceptable. This is not a matter to be settled without study or by regulation. When the Congress left capital payments out of the DRG system in the 1983 amendments it was clearly our intent to revisit this issue, and that is exactly what we will do this year.

Some change in the method of paying for capital is likely. More and more members of Congress are questioning the wisdom of continuing to pay a large share of whatever capital expenditures a hospital chooses to make.

But, as we proceed to deal with this difficult issue, I believe it is very important for us to be concerned not only about the incentives for each hospital to operate efficiently, but also about the size and configuration of the hospital industry generally, and how that affects patients' access to quality care.

We need to be very concerned about the needs of those hospitals that have high capital costs now because of recent major projects. There must be adequate provision for existing obligations that were made in good faith.

We should also be particularly concerned with those hospitals that provide essential community services but have not been able to get the capital they need for renovation or replacement. These hospitals will not be able to get financing under the Administration's plan or under the current legislative proposals. It may well be that these hospitals' problems cannot be entirely solved by a Medicare capital policy, but we should try to help them to the extent possible.

We also need to be careful about the size of the cuts that are made. The Administration is trying to use changes in capital reimbursement to achieve large budget savings. This is unrealistic and unwise. If we try to save so much in the payment structure, expecially on top of the squeeze we've made over the last two years, we will create new problems for Medicare beneficiaries' access to care and we may compromise the quality of care for everyone.

We are looking at a number of alternative approaches. It might be a good idea to separate moveable equipment from other capital, and fold the moveable equipment portion into the DRG payment first. This improves the incentives for management efficiency and helps those hospitals that have immediate need for capital. At the same time it is less burdensome to hospitals, since equipment needs are relatively stable, while reconstruction and other major projects occur in cycles.

We would also be very interested in approaches that are likely to assist needy hospitals -- particularly public and community hospitals with a disproportionate share of low-income patients -- in obtaining access to capital financing. In doing so, it may be sensible to give States some discretion in managing capital resources in a way that might serve the State's system and the State's poor.

Medical malpractice

Another area that is getting serious Administrative and Congressional attention is the issue of liability insurance. There are two specific areas of insurance that are before my Subcommittee now that I think may be of interest to you.

The first is medical malpractice liability and the newest insurance crisis. I am prepared to work on this issue, although the legislative solutions to it, especially from the Federal level, are not obvious.

As some of you may know, I have long felt that malpractice solutions should be sought at the State -- not the Federal -- level of government. It is principally the States that determine tort law, license physicians and hospitals, oversee the quality of medical care, and regulate insurance companies. My own experience as Chairman of the California Assembly's Select Committee on Medical Malpractice during the crisis of the early 1970's convinced me that State government can and should exercise its jurisdiction in this arena.

California and many other states have exercised their authority and enacted tort reform legislation over the past decade. But, in spite of these actions, it seems that the situation may be getting very serious once again.

Perhaps new problems have arisen with malpractice insurance that cannot -- or at least will not -- be resolved at the State level. I do not know that this has happened, but I am certainly willing to hear the case and listen to all of the arguments.

I have begun a series of hearings before the Health Subcommittee on malpractice issues and I intend to continue them this Spring. These hearings will examine the basis for the malpractice and insurance problems that I understand many physicians have experienced.

At our first hearing, I was very concerned when I heard about physicians who must close their medical practices because of problems with insurance -- even though they may never even have been sued. One orthopedic surgeon told us how his $90,000 annual salary earned in a very busy practice turned into a $9,000 loss after paying his liabiity insurance and his student loans. He has never had a claim filed against him.

I also was very concerned when I heard about obstetricians who refuse to provide labor and delivery services because of fears of liability, and about nurse midwives facing even more serious problems as their insurance is simply cancelled. The Subcommittee was most distressed to learn that several newborn infants died unnecessarily during a period when a Community Health Center was forced to shut down its maternity services because it could not afford liability insurance.

We need to know why premiums are rising so fast, and why some health care professionals cannot get insurance at <u>any</u> price.

We need to know how much of the problem arises from increased litigation and higher awards and how much comes from declining income of insurance company reserves.

We also need to know how much of what is happening in malpractice is a symptom of a broader crisis in liability insurance in our society.

These problems are not really new. Nor are they confined to the medical care area. But there is no agreement on the cause of the problems.

People who need insurance, the insurance companies, the lawyers who bring suits on behalf of victims -- each group has a different explanation for what is happening. Each group also has some facts on its side.

Because of this confusion and because of the tradition of state responsibility, it is important that the Congress explore the current situation in depth before deciding whether federal action is necessary -- or would even help.

We have begun that process.

Vaccine Compensation

We have also begun the process of examining and, I hope, addressing another area of liability--an area that is unique in its policy implications for both public health and tort liability--vaccines.

Childhood immunization has created a public health revolution in this country. Not that many years ago there were thousands of cases of polio and millions of frightened families each summer. Last year there were five cases.

But over the past few years, the price of vaccines for such diseases as polio and whooping cough have skyrocketed, and much of this price increase has been attributed to liability costs.

The problem is simply this: Although almost everyone agrees that vaccination is good for the Nation, vaccines are not completely safe, and some vaccines are more dangerous than others. Children who are completely healthy may be seriously injured or killed by routine immunization.

The response has been an increase in the numbers of lawsuits filed, a reluctance of manufacturers to stay in the market, difficulties in getting liability insurance for manufacturers, and a real reservations by many parents about having their children immunized.

This is a problem of unique public health importance:

* Every dollar society puts into vaccine may save as much as 90 dollars in medical costs.

* Since vaccines are not 100 percent effective, it is important for all children to get immunized to protect the society against the recurrence of disease.

And because of these public health concerns over the years, we have already made one unique change in law regarding vaccines: All 50 States require that children be immunized before beginning school.

This is not an assumed risk, this is not true consent. Vaccine injury is a danger we require all families to expose themselves to, for the public good.

Again, the answer to this problem is not simple. Parents with disabled children and manufacturers without insurance both have proposed solutions, as do physicians, public health groups, and the Administration.

After two hearings and an extensive industry survey, I have begun legislative work with my colleagues on the Subcommittee. A lasting resolution must include compensation for injured children and some tort reform. I hope to have legislation introduced for consideration very soon.

Drugs--Generics and prices

Patent-term/ANDA

Another legislative concern for those of you who follow the pharmaceutical industry is the area or brand-name versus generic drugs. The recent patent-term and generic drug legislation has already begun to produce dramatic reactions, some good and some bad, and the Congress will be following those carefully this year and for some time to come.

Although many of you are familiar with the law, let me outline briefly what it is intended to do. First, it permits the FDA to approve generic copies of brand-name drugs licensed after 1962. Second, it provides major incentives for the development of new drugs by extending patent life and giving some exclusive marketing privileges.

These two changes have already begun to revolutionize parts of the industry. By permitting generic drug makers to copy post-1962 brand-name drugs as soon as patents expire, the Act allows over 150 drugs to be made available in generic form. These include many of the best-sellers such as valium, motrin, and inderal.

For the first time, there will be price competition on these drugs, and the resulting consumer savings have been conservatively estimated at a billion dollars over the next decade. The 1986 Industrial Outlook of the Commerce Department goes further and says that the generic industry will show an increase in sales of more than a billion dollars in 1986 alone, and that by 1990 about 30 percent of all prescription drugs will be generics.

This is just a beginning of the impact of the law. As insurance companies, hospitals, and public programs become familiar with possible savings, many will begin to shift to generic products.

The legislation also provides for significant incentives for the development of new brand-name drugs. The tax credits for research equal 25 percent of the increase in research budgets. The patent extensions restore much of the time required for a pharmaceutical house to test and license the drug and may extend marketing protections for as long as five years.

Problems: Anti-generic campaign

But unfortunately some of the brand-name industry has responded not with re-doubled research efforts, but with an anti-generic campaign. Some pharmaceutical groups are engaged in a multi-million dollar campaign to discourage the use of generic drugs by raising fears and doubts in consumers' minds about the safety and efficacy of generics.

The public and the health care system are the losers in such a campaign. The elderly use thirty percent of the prescription drugs in the U.S. and Medicare does not pay for drugs. Moreover, nationwide data show that 80 percent of the drugs in the U.S. are bought without any insurance, leaving consumers with the full burden of increased costs.

And--adding injury to insult--brand-name pharmaceutical houses are increasing costs of drugs at a phenomenal rate, with no justification other than price gouging. Over the past four or five years, while the CPI has risen a total of about 25 percent, the price of some of the best-selling drugs has risen 65 to 90 percent, sometimes by as much as 25 percent a year.

Such activities do not represent a good-faith response to market pressures. They certainly are not much justification for extensions of patent and marketing rights. And at a time when much of the health care industry is under severe cost constraints, they are a source of great concern to all payors.

Over the next year and on, we will continue to review the anti-generic campaigning and pricing of brand-name drugs.

AIDS

Let me conclude by discussing a major development that the financial industry has been late to notice in American health care: the AIDS epidemic.

The epidemic began in this country in 1981. Since that time, almost 20,000 cases have been reported to the Centers for Disease Control. More cases were reported last year than in all previous years combined and the total is expected to double again next year. It is estimated that at least a million Americans have been exposed to the virus.

This is a serious problem for all of the American health care system. Nationally, the average cost of caring for an patient from diagnosis to death has been estimated to be over $100,000. Ten cases cost the system over a million dollars. Almost forty cases are reported a day.

If the epidemic continues, life and health insurance companies stand to lose hundreds of millions of dollars.

Hospitals stand to lose millions more, since many people have no health insurance now, and, as health insurance companies start to screen out individuals with antibodies, fewer will be able to get it.

Lost productivity has been estimated to have been in the billions already.

At the time of the initial outbreak of the disease, it is easy to understand why it might have been regarded as a minor issue. But I am at a loss to understand how the American health care industry and the financial community have failed to recognize the significance of the epidemic now.

Powerful health lobbies have stood by, perhaps afraid of the controversy, as research budgets and education campaigns have been debated. Influential insurance and hospital lobbies have left the work of protecting their financial reserves to the National Gay Task Force and other diligent but small groups.

Your clients have a direct financial interest in making certain that the Federal government responds fully to the epidemic--with research, drug development, and education. But the Reagan Administration--penny-wise and pound-foolish and afraid to be seen helping gay men and drug abusers--has consistently short-changed all efforts. Your clients will have to pay for that neglect.

Conservative analysts and boards of directors must recognize that AIDS is not just a public health crisis but also a fiscal one. Stockholders should not be content to hear that CEO's have side-stepped the appeal for information and for research.

I ask you, as you go back to discuss capital and DRG's and insurance and patents, go back and discuss AIDS with your clients also. Perhaps private initiatives can help in areas that the government ignores. Perhaps you can lend your support to public work. But you can't afford to dismiss the issue.

Conclusion

As you can see, the Congress has a lot of work to do over the next year or two. I wish I could promise you that it would be done in a deliberative manner--looking at the market's failure to provide care for the poor and the elderly or its difficulty in regulating insurance.

But I'm afraid that the short-term budget issues will dominate all debates. I urge you and your colleagues to bring some cooler analysis to the legislative process, arguing that sensible budget policy should serve long-term goals.

I look forward to working with you.